TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Rubeena Khan, D.C.

Respondent Name
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-17-1754-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
February 7, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED TO DATE"

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment has been on hold as we have not received the W9 form that matches the tax ID number on the bill."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2016	Designated Doctor Examination	$650.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - C49 – We are unable to match your TIN and/or billing provider name with the IRS. See below for additional information to resubmit your bill.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- Notes: "In order for your bill to be processed we will need an updated W-9 form (blank form can be obtained from IRS.gov website) with the Billing Provider name that is registered to the IRS. If the name on the bill is a DBA, please list the DBA name on the second line of the form. The form must be signed and dated. The attached letter, updated W-9 form and the bill should be resubmitted …"
- 18 – Exact duplicate claim/service.
- 224 – Duplicate charge.

Issues

Is Indemnity Insurance Company of North America's reason for denial of payment supported?

Findings

Indemnity Insurance Company of North America denied the disputed services with claim adjustment reason code C49 – "WE ARE UNABLE TO MATCH YOUR TIN AND/OR BILLING PROVIDER NAME WITH THE IRS." Review of the submitted documentation finds no information to support that the federal tax identification number listed in box 25 of the CMS 1500 is assigned to the billing provider listed in box 33 of the CMS 1500 provided to the division. Indemnity Insurance Company of North America's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	May 5, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.